COUNTY OF Placer

MENTAL HEALTH, ALCOHOL, AND DRUG ADVISORY BOARD

Placer County Mental Health, Alcohol and Drug

FISCAL YEAR 2015 – 2016 ANNUAL REPORT

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PLACER COUNTY MENTAL HEALTH, ALCOHOL AND DRUG BOARD

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DISTRICT 3
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Supervisor: KIRK UHLER

Janet O'Meara

DISTRICT 5
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Sharon Stanners (*Vice-Chairperson*)
Theresa Thickens (*Chairperson)*

*7/1/2015 - 6/30/2016

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The Placer County Mental Health, Alcohol and Drug Advisory Board (MHADB) is submitting this Fiscal Year 2015-2016 Annual Report to the Placer County Board of Supervisors as required by Welfare and Institutions Code (5604.2).

I. EXECUTIVE SUMMARY

REPORT PURPOSE AND ORGANIZATION

The goal of this annual report is to provide a snap-shot of Placer County's mental health, alcohol and drug programs, facilities, and consumer interests; challenges and recommendations are also highlighted for consideration. This *Executive Summary* contains a concise list of Fiscal Year 2015-2016 Board highlights and a summary of committee activities in the form of *Committee Briefs*. The *Board Overview* section provides a description of Board composition, roles, and responsibilities. The body of the document follows with detailed *Committee Reports* expanding on each committee's area of responsibility. Finally, the report concludes with a summary of Fiscal Year 2015-2016 *Board Trainings and Presentations*.

FISCAL YEAR 2015-2016 BOARD HIGHLIGHTS

Alcohol and Other Drugs Committee

- ✓ Affordable Care Act (ACA) Drug Medi-Cal Services
- ✓ Criminal Justice System Services

Quality Improvement Committee

- ✓ County, State and Federal Standards Compliance
- ✓ Continuum of Care Reform (CCR-AB 403)
- ✓ California Mental Health Boards and Commissions Data Notebook
- ✓ Quality Improvement Monitoring

Children's Services Committee

- ✓ Sprouts Therapeutic Pre-school Program
- ✓ Psychotropic Medication and Foster Children
- ✓ Competent Trauma Informed Care
- ✓ Early Intervention and Prevention in Schools
- ✓ Sexually Exploited Youth
- ✓ Katie A. (Dependency Mental Health Settlement)

Joint Children's and Quality Improvement Subcommittee

- ✓ Educationally Related Mental Health Services (ERMHS-AB 114)

Adult Services Committee

- ✓ Assisted Outpatient Treatment (AOT) Implementation
- ✓ Housing for Persons with Serious & Persistent Mental Illness (SPMI)
- ✓ Family Members' Inclusion in SPMI Treatment and Supports
- ✓ Treatment and Outcome Data Visibility
- ✓ Full Service Partnership (FSP) Professional Competency

COMMITTEE BRIEFS

Alcohol and Other Drugs Committee

- ✓ **Affordable Care Act (ACA) Drug Medi-Cal Services** - The ACA provides increased access to eligibility for Drug Medi-Cal Services which are expanding through the recently approved Department of Health Care Services 1115 Drug Medi-Cal Waiver. Placer County is planning to opt into the 1115 waiver. The outcome of a fiscal analysis and plan details will be completed in the next fiscal year.
- ✓ **Criminal Justice System Services** - There are many excellent collaborative services through county Health and Human Services (HHS), Probation, and the Sheriff's Department. However, drug and alcohol addiction services can be improved through increased and routine collaboration.

Quality Improvement Committee

- ✓ **County, State, and Federal Standards Compliance** - Placer County System of Care is responsible for nearly 30 county, state, and federal program audits. The Board monitors adherence to these audits through continuous collaboration with county staff and provider agencies; highlights include:
  - The Department of Health Care Services (DHCS) *Draft Systems Review Report* on Placer County included an overall rating of 96% compliance. The primary area of non-compliance was in the 24/7 urgent care access lines. The *DHCS Draft Clinical Review Report* on Placer County noted problems with charts for residential facilities for youth and full service partnerships; however, because the samples for these services were very small, the outcome reflected only a minor portion of the full scope of services.
  - Internal county audit of 24/7 urgent care access lines were generally very positive. Unfortunately, test calls did not include consumer complaints and were not conducted in a language other than English. The breadth and depth of internal test calls (calls which met state Fiscal Year 2015-2016 mandates, but failed to promote better access to services) is expected to increase in Fiscal Year 2016-2017, as auditing was converted by the MHADB from a paper and pencil system to an automated system.
  - Placer County was one of 10 counties selected to participate in the *SAMHSA/DHCS Review of Substance Abuse, Prevention, and Treatment (SAPT) Expenditures.* The county received two deficiencies; one for monitoring Substance Use Services (SUS) for people with disabilities and one for tardy documentation. These areas will be addressed in Fiscal Year 2016-2017.
  - *In-Home Supportive Services Quality Assurance Review* resulted in 100% compliance rating in seven areas. The IHSS team was recognized for developing two best-practices: (1) developing a tracking spread sheet to calculate social workers' performance, and (2) developing induction training and mentoring. However, the county remains on a Quality Improvement Activity Plan (QIAP) reassessment for falling short of the 80% compliance standard. Monitoring modifications have already increased compliance to over 86.7% and should continue to improve in Fiscal Year 2016-2017.
  - *Placer/Sierra Mental Health Plan (MHP) Audit* is conducted by an External Quality Review Organization (EQRO), required by the U.S. Department of Health and Human Services (DHHS) Center for Medicaid and Medicare Services (CMS). This EQRO review is based on stakeholder interviews. Lack of a data dashboard, limited communication/involvement with direct service staff, inadequate inclusion of consumers in the QA process, and inadequate IT staffing to implement projects were all identified as areas of need. Nonetheless, high marks were received for overall improvement and Placer County projects were shared with other counties as examples of performance progress.
- ✓ **Continuum of Care Reform (CCR-AB 403)** - AB 403 fundamentally changes the way in which foster care, emergency shelter care, and group home care occur in California; group homes offering less intensive services will transition to intensive treatment homes and group homes offering more intensive services will transition to short-term residential treatment centers. In addition, county-run emergency shelters will close by January 1, 2017. An RFP was awarded to

Koinonia Group Homes to aid in the significant transitions ahead. Associated *Child and Family Services Reviews (CFSR)* will also be required for both Foster Care and In-Home Child Welfare Cases. In Fiscal Year 2016-2017, the county will complete 70, 80 page, reviews (requiring 40 hours each) annually. The county is receiving technical assistance from the state in this area, and many CWS and QA staff are now trained and certified as Case Reviewers.

- ✓ **California Mental Health Boards and Commissions Data Notebook** - The Board provided County data to the California Mental Health Planning Council (CMHPC) and the California Association of Local Behavioral Health Boards and Commissions (CALBHB/C) to help local boards compare public data of local mental health services. The Fiscal Year 2015-2016 data focused on: 1) strategies to meet the *Needs of Persons Experiencing Mental Health Crises*: *Treatment Options and Alternatives to Locked (Involuntary) Facilities*, and 2) *Integrated Care: Treating Individuals with both MH and Substance Use Disorders (SUD*).
- ✓ **Quality Improvement Monitoring** - The QI Committee focused on several new areas of interest and initiated procedural and data visibility improvements. A significant change, beginning in Fiscal Year 2016-2017, will integrate quality improvement responsibilities into each committee, rather than continuing a stand-alone QI Committee. This change will minimize the 'silo' effect and promote quality improvement across all client populations.

Children's Services Committee

- ✓ **Sprouts Therapeutic Pre-school Program** - The Sprouts Therapeutic Pre-school Program was made possible through a collaborative effort with First 5, Children's System of Care (CSOC), and the MHADB Children's Committee. However, First 5 funding for Sprouts will end after June 30, 2016. The Children's Committee recommends continuation of, and priority funding for, this important program.
- ✓ **Psychotropic Medication and Foster Children** - There has been considerable interest in the perceived problem of over-prescribing psychotropic medications in the foster youth community – particularly in group homes; this concern prompted a review by the MHADB of procedures. As a result, CSOC has developed a working group to respond to the new *California Guidelines for Use of Psychotropic Medications for Children and Youth in Foster Care* – including: a) prescribing standards, b) parameters, c) diagnostic protocols and practices, and d) an algorithm to prescribe.
- ✓ **Competent Trauma Informed Care** - Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse and other emotionally harmful experiences. Placer County adopted the *Child and Adolescent Needs and Strengths* Assessment (CANS) to promote appropriate diagnoses and treatment; mild to moderate cases can now be identified and directed to contracted providers and severe cases can now be referred to CSOC clinicians.
- ✓ **Early Intervention and Prevention in Schools** - Prior to 2014, CSOC and the Campaign for Community Wellness (CCW) identified several gaps in school-based programs. The number of services addressing early intervention - including over 20 different contract and subcontract provider services - doubled. Although providers must have an agreement with local school districts or the Office of Education before receiving funding, both have become responsive and involved in early intervention and prevention activities. The MHADB feels that early intervention and prevention activities in the schools are sufficiently robust. Over the upcoming year, committee members will continue to meet with PCOE and district administrators to share information and coordinate efforts.
- ✓ **Sexually Exploited Youth** - Commercially sexually exploited children in Placer County is becoming a growing problem. Findings suggest the driving force behind sexual exploitation of youth is societal problems *unrelated to alcohol, drug, and mental health problems*; however, there is significant fallout from such exploitation which manifests in post-traumatic stress and alcohol and drug use by children. A *Commercially Sexually Exploited Children's Joint Task Force* (CSEC), consisting of the DA, MDIC personnel, Probation, SIU, Local Law Enforcement, Stand up Placer, PCOE, and CSOC, was formed to address this societal issue, and a county-wide MOU is pending final counsel approval for new projects.
- ✓ **Katie A. (Dependency Mental Health Settlement)** - The 2011 settlement of this class action case mandates intensive in-home and community-based mental health services for California children

who are in foster care or at imminent risk of removal from their families. This settlement is intended to alter existing policies and practices in counties by improving mental health assessments; this will minimize more restrictive treatment in large facilities and group homes. Prior to Katie A., Placer County offered many integrated care and wraparound services later mandated by the settlement, therefore few changes were necessary when Katie A. went into effect. Nonetheless, important changes did occur, including additional screening and enhanced services. Also, *Child Family Treatment Meetings* for children in group homes are now required by the settlement and this requirement remains an area of concern. Katie A. implementation will be tracked under *Continuum of Care Reform* activities in the next Fiscal Year.

Joint Children's And Quality Improvement Committee

- ✓ **Educationally Related Mental Health Services (ERMHS-AB 114)** – Assembly Bill 114 transferred responsibility of Educationally Related Mental Health Services (ERMHS) from Placer County Mental Health to Placer County Office of Education (PCOE), Placer Special Education Local Planning Area (SELPA), and Local Educational Agencies (LEA; i.e., school districts). As such, the Children's Services Committee (CSC) and Quality Improvement Committee (QIC) jointly initiated a goal to better understand new ERMHS programs. Collaborative efforts between the Board and PCOE, Placer SELPA, and LEAs revealed important findings, including:
  - An upward trend, for both K8 and 9-12 student categories, in the number of unduplicated services provided.
  - Decreased Individual Counseling Services and Social Work Services, for both K8 and 9-12 student categories; this shift might reflect either reduced access to intensive services or improved early intervention services, reducing the need for intensive services, or both.
  - New ERMHS delivery models strive to avoid removing students from general education classrooms, to the extent possible, to maximize access to curriculum and peers.
  - Personnel qualified to deliver treatment, types of treatment, and outcomes related to treatment are unclear, as data linking clinicians to treatments was unavailable.
  - Supplemental trainings available to providers, and the variety of assessments used in determining eligibility, are comprehensive.
  - More data are needed to fully understand the state of ERMHS in Placer County.

Adult Services Committee

- ✓ **Assisted Outpatient Treatment (AOT) Implementation** - Assisted Outpatient Treatment (AOT) has been used in Placer County since 2015. A person with a mental illness, even when active symptoms are observed, has the right to refuse treatment. However, AOT offers the opportunity for family members or treatment providers to refer a person for treatment. The referred person must have had two or more psychiatric hospitalizations within the past 36 months, and/or have committed a violent act, or the threat of one, within the past 48 months. Placer County data show 12 clients referred to AOT in Fiscal Year 2015-2016. Of those recommended: five accepted treatment voluntarily, four are in the process of engagement, one did not meet full criteria for treatment, and two were enrolled through the court process (one completing treatment and one currently in treatment). In general, findings indicate:
  - Public education about AOT and treatment options is important to treatment success.
  - At no point in the AOT process is the client forced to take medication. If a client is perceived to be in significant risk of deterioration, but refuses medication, alternatives such as conservatorship can be considered.
  - The data show at least seven clients in Placer County are on a path to recovery as an outcome of the AOT process.
- ✓ **Housing for Persons with Serious and Persistent Mental Illness (SPMI)** - While it is well known housing is a critical need for all clients in recovery (both those with substance disorders and those with SPMI), the MHADB focused on housing serving those with the most 'high-acuity' needs (typically those that qualify for Full Service Partnership (FSP) programs). While there is a full continuum of housing available in Placer County, Supportive Housing, providing additional

services, such as financial assistance, case management, help with daily living skills, and other basic needs, is limited. In general, findings indicate:

- Although the amount of housing available for persons with SPMI is limited, the housing that is available is very well managed.
- Placer County lacks sufficient housing for persons with SPMI - primarily due to lack of available and affordable units.
- In an effort to provide additional information for those in need of housing, and their families, the MHADB's ASC created a *Housing Chart* to augment housing information provided by ASOC.
- Specific needs of homeless individuals with mental health and/or substance addiction challenges suggest mental health services *must be addressed in conjunction* with the provision of suitable housing.
- A robust effort to increase Placer County's supply of housing options for those with SPMI and high-acuity needs is a priority.

✓ **Family Member Inclusion in SPMI Treatment and Supports** - The Bronzan-McCorkadale Act created the Welfare & Institution Code governing how persons with mental illness, living in California, receive care. Families are mentioned repeatedly in these documents as vital to providing appropriate treatment. Further, the Mental Health Services Act (MHSA) includes family as an important component in quality care; however, how family inclusion translates into action is unclear. Although more data is needed, ASC prepared the following summary of findings:

- Evidence supports that proactively involving families in treatment and providing components of service that focus on the family itself, lead to better outcomes for clients and address the very real distress that families suffer.
- The term 'family' is defined by the client and may include life partners and close friends with whom the client has a trusting relationship.
- Medical privacy rights dictate that family members cannot participate in conversations with treatment providers unless the client has signed a *Release of Information* (ROI). Each provider has its own ROI form, so if a client is treated by multiple entities, a family needs multiple ROIs to participate in integrated care.
- Professional care providers appear supportive of working with, and through, families when an ROI is on file.
- Recommendations for, incorporation in Placer County programs, were created by the ASC in the form of a *Family Involvement Plan* (FIP). Components of a quality FIP include: 1) family involvement in treatment, 2) psychoeducation, 3) caregiver/family emotional and respite support, 4) informational materials on providers offering family supports, and 5) protocols for engaging families in *whatever* manner best meets the needs of the clients and families who love them.
- Additional services offing a full continuum of related family care remains a high priority for persons with SPMI.

✓ **SPMI Treatment Outcome Data Visibility** - Reviewing Fiscal Year 2015-2016 FSP data revealed important program information, but not enough to promote superior services. For example, it is unclear whether persons with higher levels of disability (such as those with schizophrenia) have the same positive outcomes as others without SPMI. As such, the ASC recommends the following related to improved data access and management:

- Enhanced longitudinal data, in numerous areas, to determine if successes are sustained by clients over time.
- Systemic annual data is useful, however it provides a big picture that can be confusing and can lack the resolution necessary to assess specific outcomes.
- Direct access to program staff and data is beneficial and necessary. For example, the ASC has requested, and received, specific data which has proved extremely useful.
- Obtaining outcome data has been problematic across the state. When the Little Hoover Commission issued a report in 2015 questioning how the large amount of MHSA monies were spent, MHSA staff struggled to respond quickly – due to the complexities of the data and the lack of effective data management.

- Consultation with data experts is important in allocating, tracking, and managing resources. Continuing Placer County's data analysis contract(s) is important in raising the capacity of providers to collect meaningful data and to establish consistent data sets for comparison.

✓ **Full Service Partnership (FSP) Professional Competency** - California's FSP follow a '*Whatever It Takes Approach'*; however, this appears less true with some clients. Chief among ASC concerns are issues brought to attention by family members of clients with SPMI. As such, the ASC met with Turning Point Community Programs (TP), a county FSP, to explore these concerns. ASC found:

- Often case managers lacked professional expertise and appeared to be learning on the job.
- As compared to TP FSP case managers, ASOC FSP case managers generally appeared better trained (with masters' degrees in social work), more effective in working with resistant clients, and more skilled in treating clients with co-occurring disorders.
- TP and ASOC appeared responsive to these concerns, by conducting productive meetings, formalizing stakeholders groups for family members, hiring a TP Training Manager, and offering a variety of in-service trainings.

Collectively, the MHADB, through its committees, found tremendous efforts to provide appropriate treatments and superior mental health and substance use services in Placer County. The next section briefly describes Board operation in accomplishing its annual review; this description is then followed by the body of the report which details activities summarized above.

II. BOARD OVERVIEW

MISSION STATEMENT

The mission of the Placer County Mental Health, Alcohol and Drug Advisory Board (MHADB) is to promote citizen and consumer participation in planning, providing and evaluating the mental health system of care; assist in establishing measurable client and system outcomes; review and make recommendations to the annual performance contract; and advise the Directors of the Systems of Care and Health and Human Services and the Board of Supervisors on issues relevant to the provision of mental health services to priority populations.

PRINCIPLES

The Placer County Mental Health, Alcohol and Drug Board shall be guided by the following principles:

- ✓ Promote services and programs (within the family and culture) utilizing a client-centered approach.
- ✓ Prioritize resources for those most in need of services.
- ✓ Promote services and programs that are community based and coordinated with child and adult service systems (e.g., schools, social services, health, juvenile justice, law enforcement, etc.).
- ✓ Promote services provided in the least restrictive, clinically appropriate environment.
- ✓ Foster public/private partnerships and collaboration to improve service delivery and availability.
- ✓ Enhance quality and cost effectiveness of services by establishing measures of performance outcomes focusing on the individual receiving services, family members, and the system of care delivering services.
- ✓ Provide leadership in education, prevention, early identification, and advocacy, with community and consumer participation and collaboration.

RESPONSIBILITIES

The foremost role of the MHADB is to review and evaluate the community's mental health and substance use needs, services, facilities, and special problems. To accomplish this task, the Board conducts monthly meetings in various locations within the county to facilitate reviews, receive staff reports, and solicit community input. In Fiscal Year 2015-2016 the MHADB met in both Roseville and Auburn. The regular monthly meeting is usually held on the fourth Monday of each month. In addition, the Board holds monthly committee meetings and a yearly retreat to review work and develop plans. Specifically, the MHADB responsibilities are defined in Welfare and Institutions Code Section 5604.2 as follows:

5604.2(a) Local mental health Board shall do all of the following:

(1) Review and evaluate the community's mental health needs, services, facilities, and special problems.
(2) Review any county agreements entered into pursuant to Section 5650.
(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.
(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.
(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The Board shall be included in the selection process prior to the vote of the governing body.
(7) Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.
(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health Board.

5604.2(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the Board shall assess the impact of the realignment of services from the state to the county on services delivered to clients and in the local community. (Amended by Statute 1993, Ch. 564. Sec. 3. Effective January 1, 1994.)

BOARD COMPOSITIION

The MHADB promotes citizen and consumer participation in planning, providing, and evaluating mental health and substance-use-disorder services in Placer County, and is comprised of consumers and family members who are receiving, or have received, mental health, alcohol or drug services. In addition, the Board includes individuals who have experience and knowledge in mental health, alcohol and drug systems of care. The Board carries out its duties with the guidance from its *Executive Committee* and working committees. Both Board members and community volunteers serve on the following committees and subcommittees: *Alcohol and Other Drugs Committee*, *Quality Improvement Committee*, *Children's Services Committee, Joint Children's and Quality Improvement Subcommittee, and Adult Services Committee*. The next section details the work of each of these committees in Fiscal Year 2015-2016.

III. ALCOHOL AND DRUG COMMITTEE REPORT

In Fiscal Year 2015-2016, the Alcohol and Drug Committee (AOD) continued to learn about, provide feedback on, and observe substance use and related services in Placer County. The AOD committee is committed to furthering excellence in the service delivery system of substance using clients and preventing the misuse of alcohol and drugs in Placer County. In furtherance of this mission, the committee continued to stay abreast of local services and programs for substance abusing clients and learned about changes occurring at a statewide and national level that impact local service delivery.

County staff from multiple departments, consumers, and private providers offered their perspectives on current services, outcomes, and service gaps. Information was obtained both in presentations to the committee and visits to programs and consumers within the community. Through staff and program presentation as well as outreach activities, the committee became informed and advocated for the treatment needs of those with substance use issues. Specific activities related to the committee's Fiscal Year 2015-2016 goals are outlined below.

A. Affordable Care Act (ACA)

Goal: Learn about how the waiver is impacting service delivery for substance abusing clients in Placer County.

Findings: Committee members received reports and presentations from County staff particularly focused on the development of the 1115 waiver. The changes to the organized delivery system for substance use services hope to increase access to residential treatment, case management, recovery services, medication assisted treatment, youth treatment, etc. The ACA provides increased access to eligibility for Drug Medi-Cal Services which are expanding through the recently approved 1115 waiver.

Status: Placer County is currently engaging in the waiver planning process with the current intent to opt into the 1115 waiver. The outcome of the fiscal analysis and the ability for the county to create a plan to opt in will occur in the next Fiscal Year. This group will continue to stay up-to-date on progress toward system redesign and impacts to access to services.

B. Criminal Justice System

Goal: Continue to be educated on updates from probation, courts, etc., on recommendations for improved criminal justice processes.

Findings: The committee attended drug court - an opportunity to see clients addressing substance abuse issues, family and employment concerns and legal situations in a collaborative manner. A presentation was made to the Board by Placer County Probation describing re-entry services that start in-custody. This focused on the medium and high-risk offenders, beginning with a needs assessment that identifies issues which caused criminal behavior. Included in this program (Placer Re-Entry Program or PREP) is job readiness, anger management, batterer's treatment program, theft classes and GED classes.

Status: The committee has learned that there are many excellent collaborations/services happening through the collaboration between Health and Human Services (HHS), Probation and the Sheriff's Department. The committee will continue to receive updates and provide feedback on this subject. The committee is aware that drug and alcohol addiction problems can be addressed through collaboration with the criminal justice system and that all parts of the system need clear communication and collaboration with each other. The committee will

continue to encourage collaboration between HHS, Probation, community partners, legal services, healthcare, etc. Although this goal has been achieved, the committee will continue to hear updates about the PREP and the impacts to outcomes for those struggling with addiction.

C. Continue Heroin Updates

Goal: Become more informed on the use of heroin in Placer County. Rates of use, ways people are accessing heroin, prevention efforts, and treatment strategies. Make recommendations and advocate for prevention of heroin use and expanded treatment options for heroin abusing Placer County residents.

Findings: Committee members received reports and presentations from County staff regarding treatment and usage in Placer County. Committee learned about "Naloxone," an opiate overdose antidote. This blocks the brain's dopamine receptors-thus combating heroin and opiate overdoses. Committee visited Aegis Treatment Center in Roseville, receiving a tour of facility as well as meeting with program directors. Interesting findings were the large population of clients that are currently employed, how quickly many develop addictions (to prescription or illegal drugs), and the breadth of the program. The program manager visited the AOD committee and provided information on how opiates affect the brain, as well as program information.

Status: This goal has been met.

D. Increase Visibility of Substance Use Advocacy

Goal: To become more visible to providers and consumers in programs related to alcohol and substance abuse. Continue visiting new and existing programs to bring Board awareness. Interact with consumers, public, and treatment professionals to inform about what committee members can provide. Find ways to advocate for better programs serving the needs of those with substance use disorders.

Findings: Committee attended provider meeting to connect with service providers contracted with Placer County. Sierra Native Alliance did a presentation of their "whole centered person" philosophy. Board members also visited Koinonia Foster Home Treatment program and Crisis Resolution Center. Their programs offer substance use treatment for severe at-risk youth and young adults along with an array of other services. The Homeless Shelter in Auburn was visited; collaboration with Placer County Mental Health was just beginning. An Area Agency on Aging "Town Hall Meeting" in Roseville was attended to gain further insight to needs of growing senior population in Placer County.

Status: During this fiscal year, several regular members of this committee left or moved to other committees and 2 new members began attending, leaving 3 members. It is the desire of the AOD committee for more members (5 minimum) who are willing to attend meetings regularly, participate in activities related to the goals, and eventually become Board members. This goal will be continued with emphasis on increased outreach.

Alcohol and Other Drug (AOD) Committee Goals for Fiscal Year 2016-2017:

1) Learn and provide input and advocacy around the expansion of substance use services as a result of the Drug Medi-Cal Organized Delivery System 1115 Waiver. As this is still at beginning stages in Placer County; learn how the waiver is impacting service delivery for

substance abusing clients in this county. This will be accomplished by consulting with county staff, visiting programs, and consumer feedback when appropriate.

2) Increase visibility of substance use advocacy. Continue to be more visible to providers and consumers (when appropriate) in programs related to alcohol and substance abuse. Committee members will outreach to 3 substance use programs, with the focus of these program visits being on: committee member training, understanding perspectives and needs of program providers, understanding perspectives and needs of family or clients when appropriate, and/or recruiting additional committee members. In addition to visiting substance use programs, committee members will attend at least 2 community meetings and/or trainings related to substance use treatment and/or prevention, with similar objectives as stated above, yet adding deeper policy level understanding of the substance use and prevention fields for increased advocacy ability.

Submitted By: Sharon Stanners, Alcohol and Drug Committee Chair
Amy Ellis, ASOC Program Manager

IV. QUALITY IMPROVEMENT COMMITTEE REPORT

Following are the goals and activities of the Quality Improvement (QI) Committee during Fiscal Year 2015-2016.

A. Monitor Adherence to County, State, and Federal Compliance Standards

Placer County System of Care is responsible for nearly 30 state, federal, and internal county program audits – several quarterly, most annually, and a few triennially. The Board monitors adherence to these audits through continuous collaboration with Placer County Mental Health staff. The following sub-goals address activities monitored by the Board occurring in Fiscal Year 2015-2016, as well as activities conducted directly by the Board to ensure compliance with standards.

Goal: *Triennial DHCS Audit*. Monitor the triennial audit conducted in November 2015 by the State DHCS. The DHCS Triennial Audit is broken into two reviews occurring simultaneously; the first is a systems review covering 199 requirements pertaining to policies and procedures such as: access, authorization, beneficiary protection, network adequacy, array of services; interface with physical health care, provider relations, program integrity; quality improvement, and administration of the Mental Health Services Act (MHSA), including MHSA cultural competence plans and quality assurance. The second triennial review covers clinical documentation of services being delivered through the County Mental Health Plan (MHP). The triennial review took place from November 2-5, 2015.

Findings: The *DHCS Draft System Review Report* highlighted that the overall system review received a rating of 96% compliance. The primary area of system non-compliance was the 24/7 urgent care access line test calls completed by DHCS. Non-compliance continues to highlight the need for ongoing testing of the Adult Intake Services (AIS) and the Children and Family Intake Services Access (FACS) lines. As detailed in the next section, the MHADB plays a key role in conducting test calls for early detection of non-compliance.

The *DHCS Draft Clinical Review Report* highlighted some problems with charts for residential facilities for youth and full service partnerships; however, because samples for both adult and child mental health services were very small, the review reflected only a marginal portion of the full scope of county services.

Further, to ensure mandated clinical standards were met, a total of 20 clinical records (10 adult and 10 child/youth) were randomly selected, with 19 being reviewed for billing claims submitted during the period of July-September, 2014, for a total of 637 claims. All but two of the records belonged to individuals who utilized a significant amount of *contracted* provider services, rather than county provider services.

Status: The county was successful in appealing many items, resulting in modification of system review findings, recoupment from the clinical review, and enhanced monitoring and testing of the 24 hour access lines. The county is currently awaiting the *Final DHCS Triennial Review Report*. Once the final report is received, a final plan of correction will be submitted. This goal is ongoing.

Goal: Perform internal audit test calls of “front door” intake performance of the 24/7 Mental Health Access Phone Lines.

Findings: Results were collated into an internal report disseminated to both AIS and FACS supervisory staff groups. Test calls to both intake lines were generally very positive, with the caller reporting feeling supported and that staff were friendly and helpful. Final data on the number of test calls and outcomes indicated a total of 13 test calls made during Fiscal Year

2015-16, with 9 (69%) made during normal business hours and 4 (31%) made after normal business hours. Review of the calls indicated 6 of 13 (46%) were both logged and included the name of the caller, as required, and 9 of 13 (69%) also recorded the date of the test call, as required. However, no test calls were conducted in a language other than English or included consumer complaints, and, therefore, failed to assess language capabilities of access lines or processing grievances, respectively.

Status: As a means of increasing the number of internal test calls (numbers in FY2015-16 met state mandates, but failed to promote superior access to county mental health services), the MHADB members, Mental Health America staff, and employees of the Placer County Quality Improvement Supervisory Team collaborated to increase both AIS and FACS test calls to numbers. In addition, state mandates are changing to include additional numerous data collection points and options for caller needs. These changes will likely require more intensive monitoring in upcoming fiscal years.

To improve intake line monitoring during this fiscal year, the QI Committee converted the internal test call process from a paper and pencil system to an automated system using Survey Monkey. The Test Call Survey is in now available on the Placer County website and is easily accessed to conduct tests calls. Staff provided instructions and passwords to Board members and test call survey prompts were sent routinely to Board members. This goal is ongoing.

Goal: Continue to monitor other quality improvement activities:

Findings:

- ✓ *SAMHSA/DHCS Review of Substance Abuse, Prevention, and Treatment (SAPT) Expenditures.* The Federal Substance Abuse Mental Health Services Administration (SAMHSA) began a review of the CA DHCS monitoring of SAPT funding.

  Status: Placer County was one of 10 counties selected by DHCS and SAMHSA to participate in this federal review. The review will continue into Fiscal Year 2016-17.

- ✓ *DHCS Annual State-County Substance Use Services Contract Compliance Review* took place in March 2016. This annual review monitors the county's compliance with the SAPT Block Grant and related contracts. This year, the comprehensive review was based on the county's responses to the State's standardized monitoring instrument, discussions with county staff, and review of supporting documentation related to identified requirements. Overall the review went well with the county receiving only two deficiencies, one related to monitoring the need for Substance Use Services (SUS) for people with disabilities and one for tardy CalOMS submissions.

  Status: This activity will continue into Fiscal Year 2016-17.

- ✓ *In-Home Supportive Services Quality Assurance Review.* The In-Home Supportive Services Quality Assurance Review by Department of Social Services (CDSS) was conducted from January 12-15, 2016. During this review, CDSS staff accompanied County QA staff on two home visits and reviewed a total of 46 IHSS recipient cases. Overall the county was recognized by CDSS for excelling (100% compliance rating) in seven areas, as well as the Leadership of the IHSS team, recognized for developing two best-practices: (1) a tracking spread sheet to calculate social workers' performance averages promoting productivity and consistency in conducting timely reassessments, and (2) an induction training including a mentoring component.

Status: The County remains on a Quality Improvement Activity Plan (QIAP) due to the annual rate of reassessments falling short of the expected 80% compliance standard. The IHSS team has made great strides in this area and is expected to successfully complete the QIAP. As of May, the IHSS Program was 86.7% compliant. This activity will continue into the next fiscal year.

- ✓ *Placer/Sierra Mental Health Plan (MHP)*. This annual External Quality Review Organization (EQRO) review is required by the U.S. Department of Health and Human Services (DHHS) Center for Medicaid and Medicare Services (CMS). Unlike other reviews, the EQRO review does not focus on compliance with regulations or contracts, but includes an evaluation of aggregated information on quality, timeliness, and access to services in the MHP. This is accomplished through a variety of stakeholder interviews with contracted providers, consumers, and direct service staff members. All MHPs are required to include two performance improvement projects (PIPS) during the year. The Placer County PIPs submitted for this review include one on the *Use of Psychotropic Medications within the Children's System of Care* and one on *Timeliness and Access to Services*. As a result of the high marks received on both PIPS, EQRO reviewers requested permission to share Placer County PIPS with other counties as an example of overall performance improvement. The county's integrated service delivery model was also recognized as strength by DHCS. The identified challenges in the MHP included the lack of a data dashboard, limited communication/involvement with direct service staff, inadequate inclusion of consumers in the QA process, and inadequate IT staffing to implement projects.

  Status: Both PIPS will continue for a second year. The MHADB will work with county staff to mitigate the deficiencies.

- ✓ *Continuum of Care Reform (CCR)*. Continuum of Care Reform – AB 403 (statewide initiative) fundamentally changes the way foster care, shelter care, and group home care occurs in California. Lower level group homes transition to intensive treatment foster homes and higher level (more intensive service) group homes transition to short-term residential treatment centers. County run emergency shelters will close or convert by January 1, 2017.

  Status: An RFP was released in late spring and was awarded to Koinonia Group Homes. At this time, the county continues to monitor the proposed implementation of the CCR through participation in both CDSS and DHCS work groups and monitoring of CDSS and DHCS *All County Notices* and *All County Letters* – information list serves to keep agencies abreast of updates. This activity will continue into the next fiscal year.

- ✓ *Child and Family Services Reviews (CFSR).* Beginning in August 2015, California counties were required to complete qualitative case reviews for child welfare services. These reviews are modeled after the Federal Child and Family Services Reviews (CFSRs), conducted by the administration for Children and Families (ACF), Children's Bureau. This new requirement includes reviewing both foster care and in-home child welfare cases. The county is expected to complete 70 reviews annually; with each case review including an 80 page document, requiring approximately 40 hours to compile. Upon completion of the initial case review, each case undergoes a second level review by county QA staff.

  Status: The Interim CSOC Director is tracking new requirements. The county has been receiving technical assistance from the state, and as a result many CWS staff and QA staff are now trained and certified as case reviewers. This goal is on-going and updated outcomes will be available in Fiscal Year 2016-2017.

B. California Mental Health Boards and Commissions Annual Data Notebook

Goal: Review and complete the *Mental Health Boards and Commissions 2015 -2016 Data Notebook.*

Findings: The Board responded to a request from the California Mental Health Planning Council (CMHPC) and the California Association of Local Behavioral Health Boards and Commissions (CALBHB/C) to provide county data for the state's "Data Notebook." The Data Notebook is a compilation of all counties outcomes related to focus areas varying each year; it is designed to help local MH Boards compare public data for evaluation of local services. One goal of the document was to facilitate a discussion of local program strengths, local unmet needs, and areas in need of improvement. The completed Data Notebook also helps the California Mental Health Planning Council fulfill federal and state reporting mandates. Specifically, the Fiscal Year 2015-2016 Data Notebook focused on: 1) strategies to meet the *Needs of Persons Experiencing Mental Health Crises*: *Treatment Options and Alternatives to Locked (Involuntary) Facilities*, and 2) *Integrated Care: Treating Individuals with both MH and Substance Use Disorders (SUD*).

Further, the county is proactive in applying for grants to assist in addressing these areas by funding a Mobile Crisis Response Team (MCT) for both systems of care, and focus on improving health outcomes of the individuals receiving these services. The outcomes related to implementation of the MCT and related grants will be available in the coming year.

Status: The Data Notebook was completed with assistance from county staff; the Board is awaiting the CMHPC and CALBHB/C final state-wide report. This is an annual activity which will continue into Fiscal Year 2016-2017.

C. MHADB Outreach

Goal: Enhanced outreach and communication to solicit Board membership and public participation in the Board and committees.

Findings: The QI Committee enhanced outreach and communication to solicit Board membership and public participation by collaborating on informational MHADB materials, updating the MHADB website, attending numerous public events, providing members as guest-speakers, and distributing outreach responsibilities to each committee, rather than pursuing independent outreach activities through the QI Committee.

Specifically, MHADB business cards were developed and distributed to enhance communication between individual Board members and persons interested in the Board. A concise and easy to read informational tri-fold was developed to: communicate the vision, mission, and purpose of the MHADB; provide information about the Board operation, committees, meeting times and locations; and to offer a variety of ways to become involved in Board activities (either as a Board member or a public participant). The tri-fold is an easy-to-digest description of the Board and was distributed at public events throughout the year. In conjunction with the tri-fold, the MHADB website was updated to be consistent in content and organization with other county boards and commissions and to provide greater visibility and access to agendas and minutes. In addition to the numerous outreach materials, many outreach activities occurred during the Fiscal Year. For example, numerous advertisements were placed in community newsletters and network partners' online updates. Supervisor Holmes contributed an Op Ed piece in the Auburn Journal that included information on the Board and generated public interest. MHADB members collaborated with community agencies to bring educational programs to the public and to provide information about the Board. Efforts

also continue to structure outreach goals for each committee. An outreach policy/plan was initiated at the Board's annual retreat and changes to the Board's Bylaws, reflecting AB1424 amendments; specifically AB1424 now allows a consumer of mental health services who is employed by a county or state to serve as a Board member if they do not hold a position in which he or she has an interest, influence, or authority over any financial or contractual matter concerning the employer, and he or she abstains from voting on any financial or contractual issue concerning his or her employer that may come before the Board.

Status: These activities have substantially increased visibility and awareness of the role of the MHADB. As a result, the Board has acquired new members and continues to process applications of potential members. This goal is ongoing and will focus on creating a guideline document for Board committees to use in establishing and prioritizing outreach efforts tailored to their specific area of responsibility. Therefore, this goal will continue into Fiscal Year 2016-17.

D. Monitoring Service Quality

Goal: Ensure the Board remains effective in monitoring the quality of services.

Findings: The QI Committee continued to focus on several new areas of interest and initiated procedural improvements for monitoring county mental health services. For example, the QI Committee participated regularly in the *Placer/Sierra County Systems of Care Quality Improvement Committee* quarterly meetings. The QI Committee also participated in site visits, presentations, trainings, and developed new, or updated existing, MHADB policies and procedures (e.g., initializing an update of the public mental health complaint process and updating Board Bylaws).

Status: FY2016-17 will focus on integrating quality improvement activities into each committee, rather than maintaining a separate QI Committee. This will be accomplished by county staff participating directly in each committee's meeting and addressing areas in need of improvement or increased monitoring, and facilitating each committee's role in ensuring quality services. Therefore, this goal is ongoing and will be addressed in each committee report in subsequent years.

E. Data Tracking and Reporting

Goal: Improve data usage to increase the quality of the systems of care.

Findings: Data visibility and clarity – The Board identified a need to tailor and elevate the visibility of outcome data, improve education on the meaning of outcome data, and make data more useful to the Board members and public. As such, an ad-hoc sub-committee was formed to collaborate with county staff in reviewing SOC and MHSA outcome data. In addition, committees were made responsible for the oversight of outcome data relevant to their specific area of responsibility.

Status: County staff prepared an ASOC Annual Report, providing an overview of the types of data the Board might consider. This report is also consistent with CSOC outcome reporting and will improve program evaluation amongst and between systems. Currently, the ASOC report contains Fiscal Year 2014-2015 data; however, as the ASOC report becomes institutionalized, data will be updated quickly and will provide a longitudinal view of services. Staff also secured additional data through the California Behavioral Health Directors Association (CBHDA). SOC staff worked closely with the Board to collect available data and remain proactive in data improvement.

Status: In Fiscal Year 2016-2017, and onward, each committee will focus on their relative areas of oversight in evaluating outcome reports, increasing visibility of such reports, and improving education and outreach on outcome data to make it more useful in improving systems of care. As such, in the future the Adult Services Committee, Children's Services Committee, and Alcohol and Other Drug Committee quality improvement goals will be found under each respective committee report.

Respectfully Submitted by: MHADB Quality Improvement Committee Members

V. CHILDREN'S SERVICES COMMITTEE REPORT

A. *Sprouts* Program Assessment

Goal: Follow the development of the *Sprouts* program in regards to program components, numbers served, success, and program needs.

Findings*:* The development of this therapeutic pre-school program was made possible through a collaborative effort with First 5, Children's System of Care (CSOC) staff, and the MHADB Children's Services Committee. Development of this program is consistent with federal and state mental health administrations identification of the imperative need for Early Trauma Informed Centers for children.

Children's Committee members toured the Sprouts program, located in the Sacramento County Children's Receiving Home, on February 10, 2016. Sprouts served a total of eleven children since opening in October 2014. Three children are enrolled at this time, whereas four to five children are required to break even financially. Obtaining client referrals remains a problem. Sacramento County has not participated, so all the children are currently residents of Placer County. There is an effort underway to form an advisory Board to address this problem, but this has not been completed yet.

There have been typical growing pains associated with starting a new program. Over time, Sprouts staff have seen the need to modify the facility and their approach to working with families and children. Providers would like children to attend for nine months to receive optimal treatment. Some children were removed from the program after only three months due to new foster home placements, concerns from parents about transference of behavior problems from other children, etc.

Status: First 5 funding for Sprouts will end after June 30, 2016. The Children's Committee supports continuation of this important program. As such, other funding opportunities will be explored with CSOC staff. We will also be monitoring and encouraging additional outreach by the Children's Receiving Home.

B. Psychotropic Medication and Foster Children

Goal: Receive training on psychotropic medication use with foster children and review procedures in Placer County.

Findings: Over the last two years, there has been considerable interest on the perceived problem of over-prescribing psychotropic medications in the foster youth community – particularly in group homes. In 2014, the San Jose Mercury News published a series of articles and videos detailing high use and misuse of psychotropic medications in the foster care population. This attention has prompted new legislation and regulatory changes. Statewide, there are 62,000 dependent youth. One state data source shows approximately 12,500 youth on antipsychotic meds. The state is currently seeking to reconcile data sets and identify accurately the number of youth being medicated.

In April 2015, the *California Guidelines for Use of Psychotropic Medications for Children and Youth in Foster Care* was produced with: a) prescribing standards, b) parameters, c) diagnosing challenges and practices, and d) an algorithm to prescribe. The guidelines set expectations for physicians, social workers, mature children and youth, parents, caregivers, tribal members, and other stakeholders to collaborate in strengthening the oversight and monitoring of medications.

In September 2015, the California Social Work Education Center (CalSWEC) produced a literature review: *Psychotropic Medication and Children and Youth in Foster Care*, stating that social workers must understand medications, medications usages, and side effects, and must monitor for efficacy of treatment effectiveness, assess for caregiver understanding, provide for education if necessary, and essentially perform a variety of functions and tasks to ensure proper use of medication and assist to reduce inappropriate usage of psychotropic medication treatment.

Status*:* This is an ongoing issue of concern that will require further review over the next year. CSOC has developed a working group that meets monthly, and staff will keep the Children's Committee apprised of the working group's progress.

C. Trauma Informed Care

Goal: Review and analyze CSOC programs to insure competent trauma informed care.

Findings: Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse and maltreatment, neglect, loss, disaster, war, and other emotionally harmful experiences. Traumatic exposures may only have transient effects resulting in no apparent harm; however, traumatic exposures often result in psychological harm, increased rates of mental illness, suicide, risk-taking behaviors, and chronic physical disorders. Exposure to trauma may increase the likelihood of substance abuse and lead to disruptions in daily functioning in educational and employment settings.[1] The committee received information and a presentation from CSOC staff regarding their programs to address trauma informed care. These include the *Child and Adolescent Needs and Strengths* survey (CANS), which helps identify central strengths and problems for youth and their parents. This tool assists in guiding treatment planning. Questions regarding exposure to trauma were recently added to the questionnaire. Mild to moderate medical cases can now be directed to contracted providers and severe cases to CSOC.

Status: This issue is of great importance to the health and welfare of children and will be reviewed by the Children's Committee periodically in the up-coming fiscal year.

D. Early Intervention and Prevention

Goal: Review and analyze CSOC programs to insure early intervention and prevention of childhood mental health issues.

Findings: In January 2016, the committee received a presentation from Jennifer Cook, CSOC supervisor of Early Childhood Prevention and Early Intervention programs. Working with the Campaign for Community Wellness, CSOC identified a number of gaps in pre-2014 programs. After starting their new plan in October 2014, CSOC doubled the number of programs that now address early intervention for kids. There are 20-25 different program providers, some of whom have subcontracted to other providers.

Most programs focused on prevention and early interventions are school-based. Therefore, providers now need to have an agreement with school districts and/or the Office of Education before receiving funding. Response from the schools in this area has been limited in the past, however collaboration in the last 18 months compared to previous years was improved in Fiscal Year 2015-2016. This improved interest may have been partially due to new state legislation requiring additional reporting and increased collaboration between the MHADB and PCOE. The "Knowing the Signs of Suicide" program is still encountering resistance in participation by

[1] California Mental Health Planning Council, Trauma-Informed Mental Health Care in California: A Snapshot.

high schools. Additionally, after identifying a gap in schools submitting portions of the Healthy Kids surveys that address mental health, schools are now showing a new interest in this area.

Status: The committee feels that CSOC early intervention and prevention activities are sufficiently robust and collaboration with schools is improving. Over the upcoming year, committee members will continue to meet with PCOE administrators to share information.

E. Sexually Exploited Youth

Goal: Review possible connections between mental health or drug/alcohol use and sexually exploited youth.

Findings: Children's Committee members participated in organizing and attending a meeting sponsored by the *Lincoln Community Resource Collaborative* to address child sex trafficking in February 2016. The committee concluded that the driving forces behind the sexual exploitation of youth in Placer County are societal problems not related to alcohol, drug, and mental health - the purview of the MHADB; however, there is significant fallout from such exploitation that manifests itself in post-traumatic stress syndrome and alcohol/drug use by children. The *Commercially Sexually Exploited Children Joint Task Force* (CSEC) met bi-monthly during the school year. The task force consists of the DA, MDIC personnel, Probation, SIU, Local Law Enforcement, Stand-Up Placer, PCOE, and CSOC. A county-wide MOU is pending final county counsel approval, and includes Stand-Up Placer as a major partner in services and supports, subsequent to their new grant project.

Status: As a goal for the upcoming year, the committee will learn more about programs in place to deal with mental health, alcohol, and drugs as a result of this issue.

F. Katie A. (Dependency Mental Health) Compliance

Goal: Receive training on Katie A. (Dependency Mental Health) requirements and monitor Placer County's compliance.

Findings: The Katie A. vs. Bontá case was first filed in July of 2002 as a class action suit on behalf of children who were not given proper services by both the child protective system and the mental health system in California. It was originally filed against the Los Angeles County Department of Children and Family Services (DCFS), Directors of the California Department of Health Services, and the Directors of the California Department of Social Services.

By some estimates, 70% of children in foster care in California experience a mental health problem at some point in their lives. Many foster children with mental health problems have been inappropriately placed repeatedly before being put in a group home.

The 2011 settlement of the class action case mandated the provision of intensive in-home and community-based mental health services for California children who are in foster care or at imminent risk of removal from their families. This settlement is intended to alter existing policies and practices in counties by promoting mental health assessments for children involved in foster care and community-based services, rather than services provided at large facilities and/or group homes. The agreement requires the CDSS and the California Department of Health Care Services (CDHCS) to provide coordinated, comprehensive, and community-based services to children at risk of out-of-home-placement or in foster care, and their families. CDSS and CDHCS will develop a Core Practice Model (CPM), a guiding framework for intensive care coordination, intensive home-based mental health services, therapeutic foster care, and the establishment of child and family teams. Counties were intended to participate in the development and implementation of the CPM.

Because Placer County Mental Health and Child Welfare staff were coordinating care of children and providing wraparound services prior to the Katie A. settlement, implementation of the new requirements did not require an overhaul of procedures. The most important changes in Placer County include:

- Rather than relying on CPS workers to individually recommend mental health assessments, all children entering or considered for entry into the Dependency System are screened for potential eligibility into the "Katie A subclass".
- An "Entry Team" completes the Mental Health Screening Tool for each child to determine the need for a more in-depth mental health assessment.
- Members of the "subclass" are receiving intensive and enhanced services, which includes assignment of a Mental Health clinician to the "Ongoing Team" that follows the progress of each child. A Child Family Treatment meeting must be held at least every 90 days to consider modifications to the Treatment Plan.

At the present time, CSOC staff believes they are complying with the new requirements with the possible exception of conducting all *Child Family Treatment Meetings* with children assigned to group homes. Because Placer County children may be placed in group homes anywhere in the state, in-person meetings are difficult to achieve. In addition, CSOC staff believes the group homes are already monitoring the mental health needs of these children.

Status: Dependency Mental Health programs are being subsumed under Continuum of Care Reform, which will be covered under a separate goal for next year. Concerns with the Child *Family Treatment Meetings* will be monitored by the MHADB.

Submitted by: Children's Services Committee Members

VI. JOINT CHILDREN'S AND QUALITY IMPROVEMENT SUBCOMMITTEE REPORT

A. Assess Educationally Related Mental Health Services (ERMHS) in Placer County

Goal: In Fiscal Year 2013-2014 the Children's Services Committee (CSC) and the Quality Improvement (QI) Committee jointly initiated an assessment of the implementation of AB 114 in Placer County; AB 114 transferred the responsibility of Educationally Related Mental Health Services (ERMHS) from Placer County Mental Health to Placer County Office of Education (PCOE), Placer Special Education Local Planning Area (SELPA), and the Local Educational Agencies (LEA; i.e., Placer County school districts). This goal continues to focus on acquiring a better understanding of new mental health program models and organization, delivery policies and procedures, and treatment outcomes implemented by school districts in the county. This goal has continued from Fiscal Year 2013-14 because little new information was uncovered in Fiscal Year 2013-2014 and Fiscal Year 2014-2015 - and many questions remained unanswered.

Findings: Although data collection of post AB114 mental health care has been difficult, many sources contribute to our current understanding of ERMHS, and are included below.

- ✓ *State Audit Report[1]:* Due to numerous parent complaints and widespread media coverage, the California State Auditor was instructed to perform an AB 114 Implementation audit on a sample of SELPAs across the state. Although the report did not include Placer County, the Auditor's findings add to the MHADB's general understanding of AB 114 Implementation in our county, and are presented here. This report sampled and audited five SELPAs throughout the state and did not include Placer County specifically:

    - Although, *generally,* the most common types of mental health services offered and the service providers did not change after AB 114, LEAs removed mental health services from many students' Individual Education Plans (IEP) in the two years after AB 114 took effect (IEPs are a contractual component of special education services).
    - Although *most* service reductions were *not* related to AB 114, such as those prompted by a student's graduation, IEP teams did not always document their rationale for removing a service. For 40 percent of the students with changes made to the type of mental health services received, or to their educational placement, since AB 114's implementation, the IEP teams did not document the rationale for changes. For 13 of the 44 students reviewed, who had a mental health services removed from their IEPs, either the LEA could not satisfactorily explain why the services were removed. In three cases, the LEA had no documentation or assurances that removing services would not have adversely affected access to the students' education.
    - The SELPAs, the California Department of Education, and the LEAs reviewed did not track educational outcomes for students who receive mental health services and thus, did not know if new programs and treatments benefited students' educational progress.
    - None of the LEAs included in the audit tracked the full cost of providing mental health services, and thus, it was unknown whether post-AB114 costs increased, decreased, or remained the same. Further, two of the LEAs reviewed did not spend all of the funding received for providing mental health services; and the California Department of Education has not formalized procedures for monitoring these funds.
    - Schools and counties could benefit substantially financially and improve student access to mental health services by collaborating with county mental health agencies to provide services to Medi-Cal eligible students (i.e., use additional categorical federal funds to provide services).
    - Although the mental health providers studied in the audit were qualified under California Teacher Credentialing, LEAs could improve their hiring practices by establishing minimum qualifications and formalizing their qualification processes.

- ✓ *Placer County SELPA, PCOE, and LEA Sources*[5]*:* During Fiscal Year 2015-2016, the MHADB, PCOE, Placer SELPA, and LEAs worked collaboratively to review the implementation of AB114 in Placer County. At the Board's request, both quantitative and qualitative data were collected, prepared, and provided by PCOE, Placer SELPA, and the LEAs. The following points summarize this data.
  - An upward trend was found, for both K8 and 9-12 student categories, in the number of unduplicated services provided to students receiving Special Education Services (i.e., ERMHS increased post-AB 114). Most services fell into Behavioral Intervention, Psychological Service, and Counseling and Guidance categories; while fewer Individual Counseling, Parent Counseling, and Social Work Services are provided to Placer County students; Day Treatment and Residential Services became negligible (see graph A at the end of this section).
  - Although these data illustrated an increase in mental health services overall, Counseling and Guidance Services and Psychological Services saw the greatest increase, while Individual Counseling Services and Social Work Services realized the greatest decline over time; all other mental health services decreased and remain consistently low. For example, since the implementation of AB 114, Individual Counseling Services decreased and remain at approximately 25% of pre-AB 114 services. Comparing initial post-AB 114 data in 2011 to the most recent data in 2015, for grades K-8 and 9-12, a shift away from Individual Counseling and toward Psychological Services occurred (see graph B at the end of this section). Although this shift may be viewed as a reduction in important intensive services, it is important to note that Placer County SELPA reports they offer a full continuum of mental health services and service delivery is offered in the Least Restrictive Environment (LRE) possible, as mandated by the federal *Individuals with Disabilities Educational Act* (IDEA) and consistent with the MHADB Mission. This service delivery model emphasizes offering services in the general education classroom to the extent possible in order to maximize students' access to curriculum and peers. The shift from Individual Counseling outside the classroom to classroom-based group Counseling and Guidance and Psychological Services, conforms to the LRE mandate. The overall impression is that the preponderance of students are benefiting with services in the LRE, where the largest number of services are delivered. Therefore, it is important to be aware that, just as a reduction in Medi-Cal services might be viewed as reduced access to services yet actually results from less need for Medi-Cal services, a reduction in intensive school-based mental health services might indeed be the result of improved student health and/or effective early intervention services that reduce the need for intensive services.
  - Students who require more intensive mental health services are served at the more intensive end of the clinical continuum with Individual Counseling outside the classroom.
  - The types of mental health treatments provided, and the qualifications of personnel authorized to deliver such treatment, is unclear, as no documentation or data linking clinicians to treatments were available. However, the collective list of supplemental trainings available to ERMHS providers was comprehensive and demonstrated clear evidence that Placer County schools strive for appropriate clinical skills.
  - Treatment outcome documentation provided a limited view of student progress (e.g., "most students eventually require less educationally-necessary mental health services"); the documentation failed to include qualitative or quantitative data - data essential in determining program efficacy and in establishing the need for additional funding, personnel, and other supports.
  - The SELPA provided an extensive list of assessments used in determining eligibility and noted that many different types of assessments contribute to identifying needs for ERMHS. However, a standardized process and rationale to determine student eligibility for mental health services does not exist in Placer County. Therefore, it is unclear how LEAs are determining ERMHS eligibility and the type of treatment needed (e.g., Psychological Services vs. Individual Counseling Services). Taken as a whole, Placer County LEAs use a plethora of instruments in their psychoeducational evaluations. However, no data was provided to

determine which LEAs use which instruments and which evaluators are qualified to conduct which assessments. For example, professional standards in testing, as presented in the *Standards for Educational and Psychological Testing* (published by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education), identify three qualification levels; such qualifications were not identified or addressed in the data provided to the Board. The new SELPA Director (Troy Tickle) reports plans to implement standards and guidelines, where practicable, to address this issue.

- ✓ *Other data related to school-age children's* mental health in Placer County[2-4]:
  - By 2014 mental disease and illness was the leading cause of hospitalization (16.4%) for children ages 0-17 in Placer County, with fractures following as a distant second cause of hospitalization (5.6%) for children ages 0-17.[2]
  - By 2014 Placer County hospitalizations for children with mental health disorders and illness, between the ages 0-17, was greater than the state average and has increased substantially between 2010 and 2013 (from 12.2% to 19.7%, respectively); although still higher than the state average, Placer County hospitalizations for children with mental health disorders and illness, between the ages 0-17, has dropped slightly from 2013 to 2014 (from 16.6% to 19.7%, respectively).[2]
  - Placer County *Healthy Kids Surveys,* required by the California Department of Education, often failed to include important data on student mental health (e.g., depression-related feelings by grade, as reported by student and/or staff).[3]
  - The ratio of students to pupil support service personnel, by type, in Placer County, included an average of one School Counselor for every 894 students and one School Psychologist for every 971 students.[4]

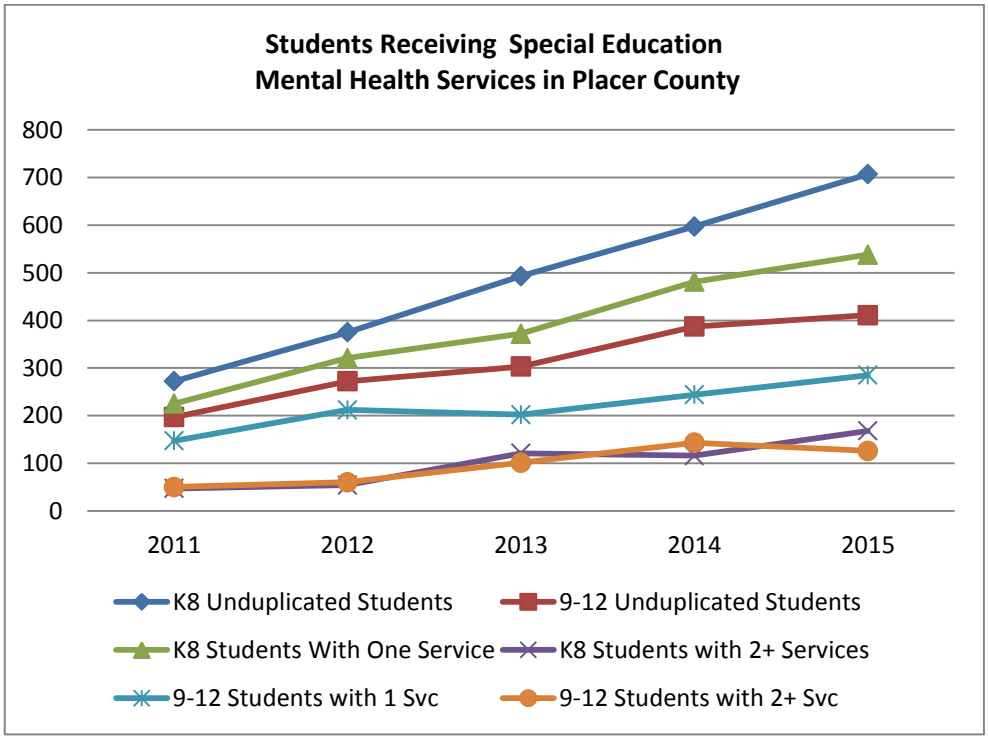
Status**:** The collaboration team should be commended for fostering and accommodating a productive process. Further, Placer SELPA, PCOE, and LEAs should be applauded for their rapid response to the MHADB 2015 data request. These data play a significant role in understanding Special Education mental health services for students in Placer County.

Because a thorough understanding of program models implemented throughout the county remains somewhat elusive, more information is needed. Therefore, after reviewing all data provided by Placer County SELPA, PCOE, and LEAs, follow-up information was requested by the MHADB. These data may contribute significantly to our understanding of ERMHS offered in the schools, and may lead to increased student access to vital mental health services.

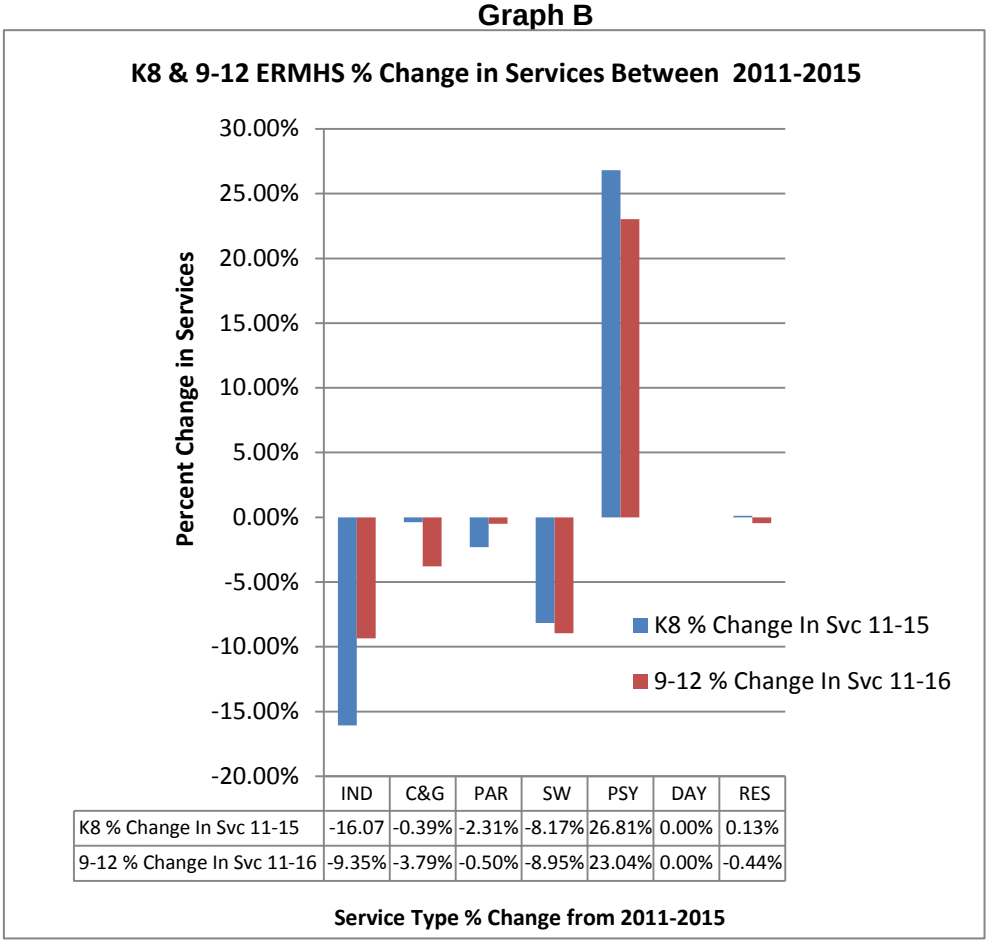
Respectfully submitted by: Quality Improvement & Children's Services Committees

SOURCES:
1. California State Auditor, Report: 2015-112.
2. California Office of Statewide Planning and Development.
3. California Department of Education, Healthy Kids Survey.
4. California Department of Education, Basic Educational Data System
5. Placer County Special Education Local Planning Area, Placer County Office of Education, and Placer County Local Educational Areas/School Districts.

Graph A



Graph B



	IND	C&G	PAR	SW	PSY	DAY	RES
K8 % Change In Svc 11-15	-16.07	-0.39%	-2.31%	-8.17%	26.81%	0.00%	0.13%
9-12 % Change In Svc 11-16	-9.35%	-3.79%	-0.50%	-8.95%	23.04%	0.00%	-0.44%

VII. ADULT SERVICES COMMITTEE REPORT

In Fiscal Year 2015-2016, the Adult Services Committee (ASC) continued to learn about and evaluate services and treatments provided to mentally ill clients of the Placer County ASOC. Meetings with county staff, community providers, consumers and families gave us perspectives and data on current services, outcomes, and provided information on possible service gaps and improvements needed.

The ASC has members from both the MHADB and the community. We benefit from attending other activities and meetings in our county, including Campaign for Community Wellness (CCW) meetings (the steering committee for stakeholders for Mental Health Services Act (MHSA planning), Recovery Happens, the Welcome Center, Placer Coalition on Housing, MHSA Oversight and Accountability meetings in Sacramento, and meetings of the California Association of Local Behavioral Boards/Commissions. Some of the presentations to the committee in Fiscal Year 2015-2016 included:

- ✓ Michael Lane, Consumer Liaison To ASOC, Updates on Consumer Initiatives
- ✓ Christi Fee, Supervisor, Mental Health America, Expansion of Family Advocate Services
- ✓ Charlotte Bill, Family member, Updates from Family Stakeholder Group at TP, Full Service Partnership provider
- ✓ Maureen Bauman, Mental Health Director, ASOC and Carolyn Bahoh, Program Director, TP, presenting on both Assisted Outpatient Treatment, and again on program growth at TP
- ✓ Reports on site visits to Cornerstone Crisis Residential, Right Hand Auburn Shelter, Lazarus Project housing, ASOC managed housing in Roseville and Auburn, Little Hoover Commission hearing on MHSA oversight in Sacramento, and the public presentations on Homelessness in Placer County by Dr. Robert Marbut, consultant

Highlights:

1. **ASC followed up on the implementation of Assisted Outpatient Treatment**. The data show that at least seven clients in Placer County are on a path to recovery as an outcome from the AOT process. That is a success for those clients, their families and our community.
2. **Quality Housing for persons with SPMI (Serious & Persistent Mental Illness).** Placer County lacks sufficient housing for persons with SPMI, primarily due to lack of available affordable housing units. However, as a matter of general priority we believe Placer County should place affordable housing that serves our SPMI residents at the top of its priority list. We would like to see a robust effort to increase Placer County's supply of housing options for those with higher needs. It is important to note, that although the amount of housing available for the SPMI is limited, the housing that is provided is very well managed. In an effort to provide additional information for families needing housing support, the ASC team has created a Housing Chart to supplement housing information already provided by Placer County.
3. **Develop an overview of current practices regarding the inclusion of family into the client treatment process, and also the parallel availability of services to meet family-specific needs.** ASC has prepared a list of recommendations that we would like Placer County to consider for incorporation. We believe it will help to encourage communication with family and clients in the treatment process and improve outcomes.

The following goals were established for Fiscal Year 2015-2016.

A. Assisted Outpatient Treatment

Goal: Assess Implementation of Assisted Outpatient Treatment (AOT).

Findings: Maureen Bauman, ASOC Director, and Carolyn Bahoh, Program Director at TP, provided the committee with an overview of how AOT has been used in Placer County since its

implementation in January 2015 to spring 2016. Statistics of usage were presented as well as an overview of the program, as not all committee members were familiar with the AOT process (commonly referred to as Laura's Law).

The data for Placer County shows that 12 clients were referred to AOT. Initially, 20 slots were expected to be held at TP for AOT clients. That has not been necessary thus far. Of the 12 clients recommended for AOT from 1/2015- 3/2016:

- ✓ Five people accepted treatment voluntarily without going through court and have stayed with it (not considered an AOT client).
- ✓ Four people were still being outreached to (with goal of creating a trust relationship).
- ✓ One person was referred but not enrolled (did not meet full criteria, or refused).
- ✓ Two people were enrolled after going through the court process with one entering and completing treatment (six-month minimum), and the other still currently engaged.

A person with a mental illness, even where active symptoms are observed, has the right to refuse treatment. AOT offers the opportunity for a family member or a treatment provider to refer a person who they fear is deteriorating in their capacity to manage their life due to the worsening of the person's mental health symptoms. There are criteria in California for when a person may be held against their will (W&I Code "5150"), but AOT tries to prevent a person from getting to that stage of severity (W&I code specifically states a person must be deemed a danger to self or others, or fall under criteria for being gravely disabled/unable to provide for own basic needs).

To meet requirements for AOT services, the referred person must have had two or more psychiatric hospitalizations within the past 36 months, and/or have committed a violent act, or threat of one, within the past 48 months. With approval from the ASOC Mental Health Director, TP will make an extensive attempt to engage the client into services while explaining that his/her situation has caused enough concern that the court may have to get involved. Many clients who are referred decide to voluntarily participate in some degree of treatment and, at that point, the AOT process is no longer necessary (per data from other established AOT programs in California and elsewhere). If the client refuses participation, and there are good indications to believe that the person is in danger of becoming further disabled, the AOT process will move forward with the court. The client is then provided an attorney to protect the numerous steps in AOT due process. Should the individual refuse to comply with having the assessment done, the judge can order that the assessment. If the assessment reveals that the client is indeed gravely disabled and unlikely to improve without treatment, and the client continues to refuse treatment, the judge can order an involuntary hold. The assessment may also return a finding that the client would benefit from treatment, but unless 5150 hold criteria is met, the client is free to accept or decline further services.

At no point in the AOT process is the client forced to take medication. While many clients do choose medication, treatment can involve many other options. If a client is still perceived to be at significant risk of further need for treatment, but continues to refuse services then alternatives such as conservatorship can be considered.

Status: The data show that at least seven clients in Placer County are on a path to recovery as an outcome of the AOT process. That is a success for those clients, their families and our community. As with any treatment, there is no guarantee the path will always move forward nor even be effective, but getting started is often the hardest step. Programs are typically analyzed (and judged) relative to rates showing decreased hospitalization and/or jail time. It will take time for enough data to accumulate in Placer County before that can be determined. Until then, Maureen Bauman, ASOC Director has put together a PowerPoint presentation on AOT to educate community groups and increase appropriate referrals.

AOT was initially understood as a means to get persons with decompensating mental illnesses, which lacked insight, into treatment. The process requires a balance between due process and the real possibility that a client (or society) is in danger due to the individual's symptoms. The fears of advocates in favor and opposed to AOT programs have not been seen thus far in Placer. AOT isn't a magic bullet for recovery nor does it return us to the time of white vans and straitjackets. Some ASC members were among the naysayers of AOT, but now are supporters. A strong component of AOT's success will be the ability of the outreach providers to build trust in clients. As successes build the committee hopes the word gets out.

The ASC believes public education about AOT is important, as is education about all of the many service and treatment options that exist within the ASOC and its community partners. The ASC will advocate for increased public communication in 2016-2017. Also, some attention must be paid to those clients who 'fail' out of AOT, but continue to be of concern. The ASC will make an effort to understand more fully related processes for conservatorship in Fiscal Year 2016-2017.

B. Housing for Serious & Persistent Mental Illness (SPMI)

Goal: Review and assessment of housing for persons with SPMI.

Findings: The ASC has reviewed issues around housing over the past few years. Housing is a huge problem in Placer County for many homeless and advocacy groups, as there is a demonstrated lack of an affordable supply. While we have always known that housing is a critical need for all people on their journey in recovery (both those with substance abuse disorders and/or those with SPMI), ASC has focused more on housing that serves those with 'high-acuity' needs (typically those that qualify for FSP services). While there is a full continuum of housing available, the segment of what is called Supportive Housing for people with SPMI was the focus of the ASC review.

Supportive Housing provides additional services (aside from financial assistance) in terms of case management, help with daily living skills, and other needs. ASC felt that there was a critical need for the type of supportive housing that is delivered via a support home (rather than singular apartments or rooms) and that does not place time limits on the length of residency. Many clients of ASOC are on meaningful and productive path to recovery, but for those with greater challenges extra in-home care would build on their strengths and provide the stability needed to enhance outcomes.

The ASC focus on such needs was sharpened and inspired by a series of three public talks provided by Dr. Robert Marbut, a consultant on homelessness hired by Placer County in 2015 to get an accurate look at how this issue affects the county. Dr. Marbut spoke directly to the specific needs of homeless individuals with mental health and/or substance addiction challenges. His analyses suggested that because so many of the homeless have mental health and/or substance addiction challenges, these needs must be addressed in *combination with the provision of suitable housing* (including shelters that make provisions for these challenges). Without this tandem approach, Dr. Marbut concluded that mentally ill persons will remain homeless and at the mercy of their illnesses.

With this in mind, the ASC reviewed existing knowledge about housing for persons with mental illness in Placer County. We took a survey of the types of housing available to those clients with higher needs, and made a chart to help us keep the information organized and useful. The facilities for higher need clients broke down into two categories: 1) Supportive Group Homes/Shared Apartments managed in collaboration between ASOC and Alliance for Mentally Ill Housing (AMIH), and 2) Private Board and Care Homes (B&Cs).

The homes in the first group are managed in collaboration between ASOC and AMIH. Most of the homes are owned outright by one or the other. In all cases, ASOC provides the assessment of the client to determine the most appropriate placement. One requirement is that all residents must be able to manage their own medications (though being on medication is not in itself a requirement). AMIH provides for management of the homes which include services to the residents. Most residents already have a Personal Service Coordinator (PSC) working with them on treatment goals via their FSP program participation with TP. AMIH also provides case managers who can check in with the residents as needed and help with skills of daily living (SDL; e.g., cooking, money management, how to use public transit, etc.). A strong component of AMIH's management is leverage the use of Peer Counselors, those who have lived experience with a mental health diagnosis, as primary supports for clients.

The other type of housing, secured by those with less life skills due to disability, is the B&Cs. B&Cs are licensed to provide medication management; they also provide daily meals and other assistance such as doing laundry and maintaining the housekeeping, etc. There are three B&Cs in Placer County: two of these are privately owned and one is run by the Yolo Community Care Continuum (Harmony House, situated in the Dewitt complex).

Once the ASC housing chart was complete (listing location, number of beds, degree of assistance, permanent or transition services, etc.) three of the ASC members took a tour of two Supportive Group Homes/Shared Apartment options. One of these, Maureen's House, is a transitional home (six months maximum) in a residential neighborhood in Roseville serving adult men (up to six at a time). The second tour was at Placer Street Apartments, a complex in Auburn providing permanent shared living in individual apartments for both men and women. The Placer Street Apartment facility impressed the ASC members, with its cleanliness and neighborhood fit. The staff we met from ASOC and AMIH were gracious and generous with their time while on the tour and also in meeting a second time to answer our more detailed questions. The residents we spoke to praised their housing and gave concrete examples of how housing stability is helping their recovery process.

In a follow-up meeting with Jainell Gaines, ASOC Program Manager, and Jennifer Price, AMIH Director, we addressed a long list of questions raised during the tours. Each of the ASC members who attended have lived experience with a family member with mental illness and know of the struggle to find appropriate and decent housing. The biggest question we had was whether we had enough housing for persons with high-acuity mental illnesses. The answer, of course, was no. There are waiting lists for all the supportive housing and only a handful of the total beds are permanent (i.e., few allow an individual to live there as long as they need, which for some can be their lifetime). For clients who cannot manage their own daily self-care (e.g., reliably taking their medications and attending to their SDL), the option is a B&C home. We heard about the difficulty of running a B&C from a cost perspective, and also about NIMBY issues in general. It was acknowledged that B&Cs, while keeping a resident safe and fed, rarely have any in-home programs to further the resident's recovery process (Harmony House is an exception). The B&Cs in Placer are considered well cared for unlike those in many other areas. But without enough availability in general; clients are sometimes placed in Sacramento (TP's Program Director estimated about 36 clients are housed in Sacramento County, and six of those are in B&Cs).

Status: As a matter of general priority we believe Placer County should be making affordable housing a top concern, and under that heading we put housing that serves our most disabled residents at the top. Mental illnesses are illnesses. We only have to take a visit to the recently opened Right Hand Auburn shelter to witness the number of persons with active symptoms who are living day-to-day without benefit of the stable housing that Dr. Marbut asserted was essential for recovery. The ASC believes too many in the public have taken on the view that persons with mental illnesses are making logical choices to stay homeless; this is wrong and mean spirited.

Unfortunately, when we neglect to provide suitable housing for our residents with serious mental illness we allow them to instead wander the streets and be seen as nuisances, rather than people in desperate need of compassion and care. This keeps stigma alive.

We would like to see a most robust effort to increase Placer County's supply of housing options for those with higher needs. Whether it is called supportive housing or a B&C, our intent is to put focus on providing whatever level of in-home therapeutic care as is necessary, and provided by persons trained to do so. Also, there must be long-term placements that recognize that some residents will have limited recovery journeys and will unlikely progress to a less restrictive setting. The B&C stereotype of overly medicated residents watching endless hours of television or wandering the neighborhood in aimless fashion is not a model that is worthy of Placer's most seriously impacted mentally ill citizens.

Although some of the Sacramento County placements can be said to be the choice of the client, the ASC doesn't feel it is a choice when there isn't a suitable option in Placer County. For clients with high-acuity symptoms, their recovery process may be very slow. Independent living may not be feasible for them. We believe that the B&C model can fall short in providing a progressive array of services within the establishment. While B&Cs are staffed 24/7 (sometimes with relatives of the home's owner), staffing often holds no credentials, nor recovery-based training. There is likely not going to be appropriate programs within the B&C (such as learning to cook, or participating in tasks to maintain a sense of participation and feelings of value). Clients are dependent on their case managers (or PSC if they are with TP) for programming, which may not happen most days of the week if the placement is out-of-county (Sacramento). A quality B&C can surely provide a safe, clean and warm home, but likely one that contributes minimally to the client's recovery process (even if that progress would be minimal due to severity of illness).

Last spring ASC stated that we believed there was a housing gap for persons with SPMI who needed an option for a, potentially permanent, 24/7 supported house (supported with staff able to further therapeutic outcomes, not just a home owner/manager). ASC still feels our county should be providing a higher level of B&C experience for their higher need clients. There should be some degree of therapeutic content, rather than allowing clients to sit all day watching television. Maybe there are graduated steps in the interim, such as ramping up the use of Peer Counselors or calling upon volunteers to engage clients in daily activities. But ultimately, the ASC would like to see a high quality series of homes dedicated to those clients who may not ever be able to transition to a less restrictive setting.

C. Family in Client Treatment

Goal: Develop an overview of current practices regarding the inclusion of family into the client treatment process, and also the parallel availability of services to meet family-specific needs. (The term 'family' can also include life partners and close friends with whom the client has a trust relationship.)

Findings: The Bronzan-McCorkadale Act created the Welfare & Institution Code that governs how persons with mental illness are to receive care from the counties of California. At several places in the code, families are mentioned as being included in the process of providing treatment to consumers. The MHSA also includes family as an important component of quality care. How these statements translate into action is less clear. The ASC has heard anecdotal stories over the years from individuals who have contacted us, as well as stories shared at support group meetings held by the Placer chapter of the National Alliance for the Mentally Ill (NAMI).

Because of medical privacy rights, family cannot participate in conversations with treatment providers unless the client has signed a Release of Information (ROI). Each provider has its own ROI form, so if a client is treated by different entities, a family would need an ROI from each one in order to be able to participate in an integrated way.

However, care providers appear to be supportive of meeting with families when there is an ROI. It is particularly frustrating, nonetheless, when a loved one has not signed an ROI and thus the family has been unable to receive or to give information that they feel would help their loved one's treatment success. Families have always had a right to give information (without expecting information in return) but there is not a clear method for families to know this right. It is one of the things families learn if they contact the county's Family Advocate (FA) or NAMI.

There is, however, good evidence that proactively involving families in treatment, as well as providing components that focus on the family itself, lead to better outcomes for clients and address the very real distress that families suffer. The components of a good family involvement plan are: 1) Involvement in treatment, 2) Psychoeducation, and 3) Caregiver/Family emotional support. Several of the members of the ASC are family members and we were able to bring lived experiences to bear. In addition, Christi Fee, with Nor-Cal Mental Health America (MHA), attended ASC meetings and brought updates on services that the FA program wee adding to their spectrum of supports.

By the end of 2016 we developed a formal Family Involvement Plan (FIP) that identified: 1) providers in our county (both ASOC and community partners) that were providing any of these components; and 2) ASC suggestions for additional actions that would comprise a full continuum of family services. The ASC shared the FIP with the county supervisor of the FA program and she offered to continue working with us on some of its elements.

The ASC committee has brought the issues of families to our Board meetings for several years. Recently the ASOC Director had engaged her staff in an open discussion on what family inclusion might involve. It was good timing to add ASC input to the discussion.

Status: The FIP provides our wish list for what an integrated program could look like. A large piece of it would be an information packet (we envisioned a shiny folder) that is provided to all families, whether they have an ROI or not. Meetings between the chairperson of this committee and the supervisor at FA had started with the intent to have FA take the lead on the production and distribution of the packet. ASC envisioned that it would be made available to families (as well as other persons in support positions to the client) when their loved one enters the system (e.g., via a 5150 hold or voluntarily admission). ASC also wants to make sure consumers are receiving a shiny folder of their own. We will continue to advocate for a developed program that provides protocols for engaging families in whatever manner best meets the needs of the client as well as that of the families who love them.

D. Data Management

Goal: Identify types of, and sources for, data that illustrate outcomes for clients of services within ASOC and its community providers.

Findings: Starting with the ASC committee's research into AOT a few years back, we have looked for data that showed outcomes for the treatments/services provided for persons with SPMI. When we see numbers that show an improvement for a certain percentage of people, we have wanted to know what elements led to the lack of improvement for the others. Looking through some of TP's FSP data in 2014-2015, we found that there were various numbers for the reduction of days spent in jail, and or hospitals, but this alone didn't indicate that this was a good thing; maybe the person needed hospitalization. We wanted breakdowns by illness, and to see

longitudinal data so we could see if successes were held by clients over time. Without a degree in statistics our committee members have not been able to easily explain what data we need to see. We have looked over the large scale Annual Data reports, but they provide a big picture that is overwhelming for the limited time our committee meets. We have asked for, and received, data from some of the specific programs within ASOC and that has been more fruitful. We can ask questions from Curtis Budge, our staff liaison, and if he doesn't know the answer he can find out who does.

However, this is an issue simply because our duty as mental health board members is to oversee the programs and services provided, and to do that we need to understand not just what we offer, but whether or not programs are successful. Our focus on the ASC are those programs that affect adults and we are always addressing the question of barriers to service, either in general or to certain groups. Over the last two years we have been separating whether persons with higher levels of disability (such as those with schizophrenia) have the same positive outcomes as others. That led to deeper conversations with Turning Point and ASOC and conversations about system improvements.

ASC members started to regularly attend the QI Committee meetings to collaborate on what assistance they could provide. We learned that ASOC provides all sorts of data for various auditing activities and the Board as a whole has had a discussion on what information would be of best use to us to fulfill our obligation to be informed about services. This is covered in the QI section of this report. The best outcome of this ASC participation in the QI was just to have a discussion about the importance of data and to clear the air that we shouldn't have to feel that we are imposing when we ask for information. Receiving information allows a conversation about what is going on (including all the positives), but including areas in need of improvement; it is important that we are made aware of that as well. If a member of the public asks one of us how we know that the Systems of Care operates as they should, we need to have more to say than we assume they do. That doesn't really pass muster for a group that is supposed to be one of the mechanisms by which citizens can be kept aware of how tax dollars are being spent.

An additional finding is that data collection has been problematic across the state. When the Little Hoover Commission issued a report in 2015 questioning whether there is data to support the large amount of money spent via MHSA programs, there were many conversations about data and whether this was about the failure of programs or about the complexities of data.

Janet O'Meara, ASC Chairperson, attended a follow-up meeting of the LHC in Sacramento in the spring of 2016 and the finger seemed to be pointed at the inordinately complex task of managing, interpreting, and making public (in a less complex and thus transparent manner) the data that has been collected thus far. The MHSA Oversight and Accountability Director, Toby Ewing, outlined the issues his office encountered in trying to provide a transparent accounting of the money as well as outcome data. He said it will take years. These same issues were anticipated by Placer County when the decision was made to hire consultant and data analyst Nancy Callahan. Nancy Callahan has presented to the MHADB and at the CCW. Her process, ongoing, is to raise the capacity of providers to collect data, and to establish consistent and comparable data sets so programs can more easily be compared to one another.

Status: Because Placer is a small County, we benefit from getting to know staff and other community providers, and consumers and families, and thus have plenty of information to assure us that many people are indeed receiving very good care. We have seen over the years that our MH Director initiates new programs and that her staff implements them with competency and dedication. But we also have evidence, as seen in the numbers of persons with mental illness who take residence in our jails and shelters, that more can be done. Making the best choices for spending additional dollars are supported when good data leads to the development of solutions. This is relevant for our state, as well as our county.

E. Professional Competency

Goal: Advocate for highest level of professional competency for providers of FSP services to persons with SMPI.

Findings: In last year's annual report ASC documented a series of issues that we raised after hearing from families about concerns they had with TP's FSP program. We met with the management at TP and took their responses into consideration. FSPs in California follow a "Whatever It Takes Approach," but we felt that was not true for all clients; chief among our concerns is the persons with questionable training and expertise handling the case management of persons with very serious mental illnesses. We were concerned the PSCs were, in some cases, learning about mental illness while supporting their clients. PSCs fulfill a range of case management services such as helping clients set goals to providing direct life-skills training. PSCs come with a range of backgrounds and some may be more advanced than others in their abilities to navigate a relationship with a person with SPMI. We contrasted the degree of credentials with PSC's to that of those working on the FSP teams within ASOC. The ASOC FSP staff generally has Masters in Social Work degrees that are better suited to dealing with treatment resistant clients, as well as clients with co-occurring disorders.

While ASC was compiling its information, TP started a stakeholders' meeting for the family members of their clients. Some of the attendees of that group are on this committee (and one is on the MHADB). They reported back to the ASC about changes that were occurring at TP. To keep abreast of the totality of activities at TP, particularly in regards to the issues we raised, we put together a list of the concerns from this annual report, added what information we had, and made recommendations. We provided this to the ASOC Director and requested an update. Maureen Bauman, ASOC Director, arranged a meeting between our committee and Carolyn Bahoh, Program Director at TP.

The meeting was productive. Carolyn Bahoh had provided a written response which helped us keep track of all the new and continuing efforts TP is making to expand and improve their services. A key activity is that TP's head organization has hired a training manager. This position will be able to make sure that training is consistent between TP's programs in all California counties in which they provide services. Local training has been going on before that, however. Various staff have gone to training on different topics provided by ASOC. Two such topics were Early Psychosis Recognition and Cognitive Behavior Therapy for Psychosis. The entire staff was also retrained in the basic principles of FSP programs including the elements of Assertive Community Treatment (ACT). These areas are very important to the effective treatment of persons with SPMI.

TP had already begun to provide stakeholder meetings to allow families an opportunity to raise concerns or ask questions. These meetings were run by the Program Director herself and the families attending reported back to us that these were very helpful for being better engaged with their adult child's treatment issues (though the meetings focus is on general issues, not on the specifics of any one client). TP had recently hired its own FA and she is on task to develop more programming or materials to meet family needs. TP also collaborated on a pilot program with a private company, MyHealios, which provided one-on-one counseling/psychoeducation via telephone to several families.

Status: Our meeting provided the reassurance that TP is making good efforts to provide the services it is contracted for (including services designed for Transition Age Youth), and making improved efforts to build the skillsets of its employees so as to better serve clients. The family meetings have been scheduled to become quarterly now and we hope that this provides satisfaction with the families. If not, they have established their own standing to address it. There has been some turnover in staff at TP at the end of 2016 and there is a new Program

Director. We will continue to be supportive of family or clients who raise issues, but feel that Turning Point, even from the beginning, has been open about their challenges and earnest in their pursuit of solutions.

Submitted by: Janet O'Meara, Chairperson (term expires 7/15/2016), Yvonne Bond (Co-chairperson 2016-2017), and David Bartley (Co-Chairperson 2016-2017)

Curtis Budge, ASOC liaison; Program providers in regular attendance are Christi Fee and Michael Lane (MHA), Charlotte Bill, Family member, Lisa Cataldo, Family Member, and Patricia Reynolds-Meade, Community member/former Board member/former ASOC staff.

VIII. BOARD TRAININGS AND PRESENTATIONS

Trainings and Guest Speakers

- ✓ *July 2015*:
  - Jennifer Cook, Program Supervisor, Children's System of Care – Mental Health Services Act Prevention and Early Intervention Programs
- ✓ *August 2015:*
  - Laura Grassman, PhD, Support Coordinator and Laura Blackburn, M.S., Program Specialist with Placer County Special Education Local Plan Area – Educationally Related Mental Health
- ✓ *September 2015:*
  - MHADB Group Discussion – Review of all Committees' Goals and Input from Members and Committees on Guest Speakers/Trainers for FISCAL YEAR 2015-2016
- ✓ *October 2015:*
  - Cyndy Bigbee, Program Manager, Adult System of Care – Conservatorship Process
- ✓ *November 2015:*
  - Lisa Long, Patients' Rights Advocate, Adult System of Care – Her Role as Placer County's Patients' Rights Advocate
- ✓ *December 2015:*
  - Twylla Abrahamson, Acting Director, Children's System of Care – Overview of What's Happening and the Many Changes in the Children's System of Care
- ✓ *January 2016:*
  - Twylla Abrahamson, Acting Director, Children's System of Care – Overview of What's Happening and the Many Changes in the Children's System of Care (second half)
- ✓ *February 2016:*
  - Public Hearing – Placer County, Mental Health Services Act Annual Update Fiscal Year 2015-2016
  - MHADB Committees' Reports – Discussion about Committees' activities
- ✓ *March 2016:*
  - Dave McManus, Assistant Chief Probation Officer, Probation Department and Lauren Featherstone, Management Analyst, County Executive Office – Criminal Justice System
- ✓ *April 2016:*
  - Charlotte Bill, Diane Shinstock, Sheree Palma and Jeannine Snook – Family Panel
- ✓ *May 2016:* (Annual Retreat)
- ✓ *June 2016:*
  - Christina Ivazes, Public Educator, Children's System of Care – Coalition for Placer Youth